INTEGRITY **FAMILY CARE**

RECORDS RELEASE

REMIT THIS FORM TO YOUR PREVIOUS PHYSICIAN

☐ I am mailing myself
☐ I have requested this be faxed using the fax number below

PATIENT NAME _____ DOB _____

PATIENT ADDRESS _____

_____ CITY _____ STATE _____ ZIP _____

PHYSICIAN/FACILITY _____

TEL _____ FAX _____

PHYSICIAN ADDRESS _____

_____ CITY _____ STATE _____ ZIP _____

I authorize the use or disclosure of the above named individual's health information as described below:

☐ Complete Medical Record
☐ Other

_____

I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome, or human immunodeficiency virus. It may also include information about behavioral or mental health services and treatment for alcohol and drug use and abuse.

This information may be disclosed to and used by the following for the purpose of treatment of the patient:

☐ Integrity Family Care, 1041 Balch Road Suite 300, Madison, AL 35758 FAX: 256-774-9040

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the physician listed as Previous Physician. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise revoked, the authorization will expire on ____/____/____ or if I fail to specify an expiration date, event or condition, this authorization will expire six months from the date of signing.

I understand that once the information is disclosed, the recipient may redisclose it and the information may not be protected by federal privacy regulations.

SIGNATURE _____ DATE _____

IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT IS _____